

**Alabama Medicaid Agency**  
**LMRP Process - Effective 8/1/03**  
**Updated 1/6/04 – changes underlined**

**BACKGROUND:** To ensure that claims are being paid for medically necessary and medically appropriate procedures, Medicaid has adopted Medicare's LMRP process. LMRP is the acronym for Local Medical Review Policy. Medicare has established such policies for both Part "A" (hospital) and Part "B" (physician) claims. Medicare has done extensive research in procedure and diagnosis correlation. Their research is documented, published and open for public comment prior to implementation. So that efforts are not duplicated or contradictory, Medicaid will be adopting certain LMRPs for claims editing/payment.

**PROCESS:** Medicare posts draft LMRPs on their website as well as holds public meetings for comments. After the 45 day comment period, the draft LMRP is published in the Medicare Focus and posted on the Medicare website. Once posted and published, the policy becomes effective after a 45 day notice period. Once the LMRPs are finalized, Medicaid will consider adoption as well. The type of service, Medicaid utilization and other payment controls are considered. It is the Agency's intention to review/adopt policies as they are released. In early 2004, all existing LMRPs will be reviewed for consideration/adoption as well.

Policies will be established for hospital and physician services based on Medicare guidelines. If the LMRP number begins with an "A", the policy only applies to hospital outpatient services. A "B" indicates physician services. If both "A" and "B" are present, then the policy applies to all type of services billed with this procedure code. Injectables, whether given in an outpatient setting or physician's office are governed by the indicated policy. EXCEPTION: The same criteria applies to both physician and hospital billing for MRIs, MRAs, CTs and PET scans.

Generally, Medicaid has adopted the same criteria as Medicare. On the LMRP list, there is a column indicating additions/deletions. This column indicates any differences Medicaid has adopted from the Medicare policy. Typically the difference is to account for pediatric diagnosis codes that Medicare does not cover.

**EDITING:** The diagnosis code edits are upfront edits that will prevent a claim from paying. There is not an ABN (advanced beneficiary notice) process in place. A Medicaid recipient should be told prior to the services being rendered that it will not/may not be covered for service. In the Medicare LMRP, there are clinical indications that must be present. The documentation must be present in the medical record but will not be edited. If a claim is denied for diagnosis code criteria not being met, the medical records should be reviewed, corrections made and the claim resubmitted through the regular claims processing system.

On a HCFA 1500, the detail diagnosis code must be on the included list. On an outpatient UB-92, the primary diagnosis code must be on the included list. Effective with HIPAA implementation, the system will recognize all eight diagnosis codes on the UB-92 and up to four per detail on the HCFA-1500.

**EFFECTIVE DATES:** LMRPS will be added at the beginning of a quarter. Prior to the effective date, providers will be notified to look for new LMRPs through EOP mini-messages, notification in the Provider Insider and through the various associations. LMRPs will be posted on the Agency's website under "What's New." To eliminate errors, Medicaid will not re-publish the LMRP in its entirety, rather the Medicare LMRP will be referenced. If there are any differences, then those will be detailed in the additions/deletions column. The effective date is for claims processed on or after. LMRPs are not date of service driven.

**CODE ADDITIONS/DELETIONS:** If a provider questions the inclusion/exclusion of a procedure or diagnosis code, then the provider should request that Medicare add/delete the code. Please refer to Medicare's LMRP process for instructions on how to contact Medicare in requesting a change. In

instances of where the code in question is specific to the pediatric population, the documentation should be sent to Medicaid. Since Medicare does not have a pediatric population, these codes are often excluded. The documentation does not need to be lengthy but rather explanatory. Medicaid specific code additions may be made weekly. As changes are made in Medicare's policies, Medicaid will make changes as well with the exception of deletions. Since we cannot edit diagnosis code criteria by date of service, old diagnosis codes may be present for a period of time until all outstanding claims are processed.

**CONTACT:** If you have any questions about the LMRP process, you may contact your EDS representative or the Agency at (334) 353-5263. Documentation for code addition/deletion should be sent to Leigh Ann Payne, Medical Services Division, P.O. Box 5624, Montgomery, AL 36130-5624.

**NOTE:** In most all instances we are requesting that the provider contact Medicare for inclusion of a code in a LMRP. If Medicare has granted an appeal or provisional payment, without actually adding a code the to the LMRP, please contact the Agency for further instruction.